FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043141

Facility Name: Dolton Healthcare Centre

Address: 14325 S. Blackstone Ave. (Number) Dolton (City) 60425 (Zip Code)

County: Cook

Telephone Number: (708) 849-5000 **Fax #** (708) 849-5175

IDPA ID Number: 36-4184122

Date of Initial License for Current Owners: 1-Oct-97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-04 to 31-Dec-04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 24th March 2005 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds Jan. 21st 2004

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	39	Skilled (SNF)	40	14,620	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	40	14,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	80	29,140	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,541	885	4,566	12,992	8
9	SNF/PED					9
10	ICF	10,981	1,850		12,831	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,522	2,735	4,566	25,823	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.62%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-Oct-1997

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1-Oct-1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 4,122

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 31-Dec-2004 Fiscal Year: 31-Dec-2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	154,023	22,594	4,845	181,462		181,462		181,462			1
2	Food Purchase		120,140		120,140	(10,748)	109,392	(112)	109,280			2
3	Housekeeping	67,187	21,807		88,994		88,994		88,994			3
4	Laundry	67,360	16,161	2,422	85,943		85,943		85,943			4
5	Heat and Other Utilities			77,129	77,129		77,129		77,129			5
6	Maintenance	33,690	36,509	46,000	116,199		116,199	5,775	121,974			6
7	Other (specify):*											7
8	**TOTAL General Services**	322,260	217,211	130,396	669,867	(10,748)	659,119	5,663	664,782			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,139,344	152,513	75,214	1,367,071		1,367,071		1,367,071			10
10a	Therapy			1,222	1,222		1,222		1,222			10a
11	Activities	74,589	7,980	2,521	85,090		85,090		85,090			11
12	Social Services	44,309		2,241	46,550		46,550		46,550			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,258,242	160,493	87,198	1,505,933		1,505,933		1,505,933			16
	C. General Administration											
17	Administrative	60,082		137,170	197,252		197,252	(63,675)	133,577			17
18	Directors Fees											18
19	Professional Services			15,007	15,007		15,007	2,730	17,737			19
20	Dues, Fees, Subscriptions & Promotions			29,821	29,821		29,821	(24,127)	5,694			20
21	Clerical & General Office Expenses	26,823	19,137	42,932	88,892		88,892	20,917	109,809			21
22	Employee Benefits & Payroll Taxes			271,345	271,345	10,748	282,093	22,022	304,115			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,320	5,320		5,320	2,802	8,122			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			4,129	4,129		4,129		4,129			26
27	Other (specify):* *Payroll Taxes (Sch VII)**							7,018	7,018			27
28	**TOTAL General Administration**	86,905	19,137	505,724	611,766	10,748	622,514	(32,313)	590,201			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,667,407	396,841	723,318	2,787,566		2,787,566	(26,650)	2,760,916			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Dolton Healthcare Centre #0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			97,972	97,972		97,972	(14,326)	83,646			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							7,647	7,647			32
33	Real Estate Taxes			174,711	174,711		174,711		174,711			33
34	Rent-Facility & Grounds			346,878	346,878		346,878		346,878			34
35	Rent-Equipment & Vehicles			767	767		767		767			35
36	Other (specify):*											36
37	**TOTAL Ownership**			620,328	620,328		620,328	(6,679)	613,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,676	287,845	402,521		402,521		402,521			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,710	43,710		43,710		43,710			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		114,676	331,555	446,231		446,231		446,231			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,667,407	511,517	1,675,201	3,854,125		3,854,125	(33,329)	3,820,796			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,632)	30		9
10	Interest and Other Investment Income	(7,108)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(112)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,585)	21		24
25	Fund Raising, Advertising and Promotional	(34,194)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,370)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(844)	20		28
29	Other-Attach Schedule **Page 5A attached	5,775	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (76,070)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	42,741	Page 6	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 42,741		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (33,329)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Dolton Healthcare Centre

ID# 0043141

Report Period Beginning: 1-Jan-04

Ending: 31-Dec-04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost (incurred in 2004)	$ 0	6	1
2	Deferred Maintenance Cost (allocated for 2004)	5,775	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	5,775		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(112)	0	0	0	0	0	0	0	0	0	0	(112)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	5,775	0	0	0	0	0	0	0	0	0	0	5,775	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	5,663	0	0	0	0	0	0	0	0	0	0	5,663	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(63,675)	0	0	0	0	0	0	0	0	0	(63,675)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,730	0	0	0	0	0	0	0	0	0	2,730	19
20	Fees, Subscriptions & Promotions	(35,038)	10,911	0	0	0	0	0	0	0	0	0	(24,127)	20
21	Clerical & General Office Expenses	(24,955)	45,872	0	0	0	0	0	0	0	0	0	20,917	21
22	Employee Benefits & Payroll Taxes	0	22,022	0	0	0	0	0	0	0	0	0	22,022	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,802	0	0	0	0	0	0	0	0	0	2,802	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	7,018	0	0	0	0	0	0	0	0	0	7,018	27
28	**TOTAL General Administration**	(59,993)	27,680	0	0	0	0	0	0	0	0	0	(32,313)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,330)	27,680	0	0	0	0	0	0	0	0	0	(26,650)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Dolton Healthcare Centre** **#** **0043141** **Report Period Beginning:** **1-Jan-04** **Ending:** **31-Dec-04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	**(14,632)**	**306**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(14,326)**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**(7,108)**	**14,755**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,647**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**(21,740)**	**15,061**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(6,679)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(76,070)**	**42,741**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(33,329)**	**45**

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 62,686	$ 62,686	1
2	V	27	Payroll Taxes-Officers'		Lancaster, Ltd.	100.00%	2,901	2,901	2
3	V	17	Management Fee Income	137,170	Lancaster, Ltd.	100.00%		(137,170)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	2,730	2,730	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	45,872	45,872	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	22,022	22,022	6
7	V	24	Education and Seminars		Lancaster, Ltd.	100.00%	2,802	2,802	7
8	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	10,809	10,809	8
9	V	20	Fees and Marketing		Lancaster, Ltd.	100.00%	10,911	10,911	9
10	V	32	Interest		Lancaster, Ltd.	100.00%	14,755	14,755	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	306	306	11
12	V	27	Payroll Taxes-Clerical		Lancaster, Ltd.	100.00%	4,117	4,117	12
13	V								13
14	Total			$ 137,170			$ 179,911	$ * 42,741	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	50.00%	see attached	5	10.42%	Lancaster	$ 23,302	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0%	see attached	6	12.5%	Lancaster	19,720	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	0%	see attached	6	12.5%	Lancaster	19,664	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 62,686		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773) 604.4416
Fax Number: (773) 478.1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 223,698	$ 223,698	5	$ 23,302	1
2	27	Laurence Zung	Hours Worked	48	7	8,867		5	924	2
3	17	Christopher Vicere	Hours Worked	48	7	157,762	157,762	6	19,720	3
4	27	Christopher Vicere	Hours Worked	48	7	7,911		6	989	4
5	17	Cheryl Morris	Hours Worked	48	7	157,315	157,315	6	19,664	5
6	27	Cheryl Morris	Hours Worked	48	7	7,905		6	988	6
7										7
8										8
9	19	Professional Services	Management Fees	2,360,020	7	46,963		137,170	2,730	9
10	21	Clerical Expenses	Management Fees	2,360,020	7	62,820		137,170	3,651	10
11	22	Employee Benefits	Management Fees	2,360,020	7	378,883		137,170	22,022	11
12	24	Education and Seminars	Management Fees	2,360,020	7	8,842		137,170	514	12
13	17	Administrative Consultant	Management Fees	2,360,020	7	185,978	185,978	137,170	10,809	13
14	20	Marketing	Management Fees	2,360,020	7	171,696	155,227	137,170	9,979	14
15	32	Interest	Management Fees	2,360,020	7	131,563		137,170	7,647	15
16	30	Depreciation	Management Fees	2,360,020	7	5,260		137,170	306	16
17	20	Licenses and Fees	Management Fees	2,360,020	7	16,029		137,170	932	17
18	24	Travel	Management Fees	2,360,020	7	39,372		137,170	2,288	18
19	21	Salaries-Clerical	Management Fees	2,360,020	7	726,412	726,412	137,170	42,221	19
20	27	Payroll Taxes-Clerical	Management Fees	2,360,020	7	70,836		137,170	4,117	20
21										21
22										22
23	32	Direct Interest							7,108	23
24										24
25	TOTALS					$ 2,408,113	$ 1,606,392		$ 179,911	25

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank One		X	Working Capital							7,647	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 7,647	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 7,647	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Dolton Healthcare Centre **#** 0043141 **Report Period Beginning:** 1-Jan-04 **Ending:** 31-Dec-04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	174,711	2
3. Under or (over) accrual (line 2 minus line 1).	$	174,711	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	174,711	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	144,398	8
	2000	152,961	9
	2001	171,367	10
	2002	170,647	11
	2003	174,711	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dolton Healthcare Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0043141

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-02-414-056-0000	Long-Term Healthcare	$ 157,462.48	$ 157,462.48
2.	29-02-422-001-0000	Long-Term Healthcare	$ 17,248.74	$ 17,248.74
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 174,711.22	$ 174,711.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,952 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

*** None ***

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Excavation and Site Work			2000	36,732	2,544	20	2,544		13,838	9
10	Concrete Work			2000	23,650	606	20	606		2,753	10
11	Masonry Work			2000	35,757	917	20	917		4,164	11
12	Steel and Erection			2000	24,818	636	20	636		2,889	12
13	Roofing			2000	15,130	388	20	388		1,762	13
14	Storm Drainage			2000	15,740	1,090	20	1,090		5,929	14
15	Plumbing			2000	38,800	995	20	995		4,519	15
16	Fire Alarm System & Protection			2000	33,664	863	20	863		3,920	16
17	Heating & Cooling			2000	26,640	683	20	683		3,102	17
18	Electrical			2000	58,592	1,502	20	1,502		6,823	18
19	Nurses' Call System			2000	12,691	325	20	325		1,477	19
20	Phase I Expansion			2000	257,605	6,605	20	6,605		29,998	20
21	Hand Rails			2001	5,424	139	20	139		492	21
22	Alarm Systems			2001	3,734	96	20	96		340	22
23	Electrical			2001	2,149	55	20	55		195	23
24	Wall Coverings			2001	7,602	195	20	195		691	24
25	Fire Proofing			2001	4,301	110	20	110		390	25
26	Construction			2001	125,945	3,229	20	3,229		11,438	26
27	Interior Design			2001	22,500	577	20	577		2,043	27
28	Architectual			2001	40,401	1,036	20	1,036		3,669	28
29	Flooring			2001	4,478	115	20	115		407	29
30	Signage			2001	3,832	98	20	98		347	30
31	Plumbing			2001	2,400	62	20	62		219	31
32	Fire Dampers			2001	8,462	217	20	217		678	32
33	Fire Security Board			2002	4,500	605	20	643	38	1,768	33
34	Roofing			2002	10,820	277	20	1,082	805	2,435	34
35	MDP Panel/Ducting			2002	4,159	107	20	416	309	867	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roofing Stage 1	2003	$ 8,020	$ 206	10	$ 802	$ 596	$ 1,404	37
38	Walkway	2003	968	25	10	97	72	162	38
39	Gutters & Scuppers	2003	6,460	166	10	646	480	1,023	39
40	Roofing Stage 2	2003	10,400	267	10	1,040	773	1,387	40
41	Electronic Egress Door	2004	3,007	68	10	276	208	276	41
42	6 Steel Doors & Frames	2004	10,152	76	10	338	262	338	42
43	Vinyl Tiles in Corridor	2004	1,939	10	10	48	38	48	43
44	2 Steel Doors	2004	4,489	24	10	112	88	112	44
45	Refurbishing of 22 Rooms	2004	10,900	245	10	999	754	999	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 886,861	$ 25,159		$ 29,582	$ 4,423	$ 112,902	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 204,784	$ 21,089	$ 42,458	$ 21,369	7	$ 122,013	71
72	Current Year Purchases	81,959	49,176	10,764	(38,412)	7	10,764	72
73	Fully Depreciated Assets	93,732	2,854	842	(2,012)	7	93,732	73
74								74
75	TOTALS	$ 380,475	$ 73,119	$ 54,064	$ (19,055)		$ 226,509	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,267,336	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 98,278	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,646	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (14,632)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 339,411	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Dolton Associates (an unrelated entity)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 342,370			3
4	Additions							4
5		**Off-site public storage space**			4,508			5
6								6
7	TOTAL				$ 346,878 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning 1-Oct-1997
    Ending 30-Sept-2022

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2005	$ 345,427
13.	12/31/2006	$ 354,597
14.	12/31/2007	$ 354,597

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 767 Description: Dish Washing Machine @ $63.95 per month
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 146,469	$		$ 146,469	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,605			3,605	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			137,771			137,771	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				78,736		78,736	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**Medical Supplies**	39-2					20,304		20,304	13
	Other (specify): **Specialty Beds**	39-2					15,636		15,636	
14	TOTAL			$		$ 287,845	$ 114,676		$ 402,521	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 **Report Period Beginning:** 1-Jan-04 **Ending:** 31-Dec-04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 41,288	$	1
2	Cash-Patient Deposits	11,536		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,061,451		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,405		6
7	Other Prepaid Expenses	1,312		7
8	Accounts Receivable (owners or related parties)	225,195		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,355,187	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	886,862		15
16	Equipment, at Historical Cost	380,477		16
17	Accumulated Depreciation (book methods)	(393,084)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 874,255	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,229,442	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 121,059	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,536		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	208,022		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,895		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 350,512	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 350,512	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,878,930	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,229,442	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,710,038	1
2	Restatements (describe):		2
3			3
4	**Adjustment in Book Depreciation for Taxation**	11,185	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,721,223	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	657,707	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(500,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 157,707	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,878,930	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,630,756	1
2	Discounts and Allowances for all Levels	(1,006,523)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,624,233	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	751,971	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 751,971	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,872	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,067	19
20	Radiology and X-Ray	8,530	20
21	Other Medical Services	22,698	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 127,167	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,108	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,108	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	1,353	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,353	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,511,832	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	669,867	31
32	Health Care	1,505,933	32
33	General Administration	611,766	33
	B. Capital Expense		
34	Ownership	620,328	34
	C. Ancillary Expense		
35	Special Cost Centers	402,521	35
36	Provider Participation Fee	43,710	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,854,125	40
41	**Income before Income Taxes (line 30 minus line 40)****	657,707	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 657,707	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** ***Cash Basis Taxpayer***

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,970	2,099	$ 68,621	$ 32.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,045	11,572	316,319	27.33	3
4	Licensed Practical Nurses	11,544	12,380	265,561	21.45	4
5	Nurse Aides & Orderlies	49,304	52,142	488,843	9.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,965	2,110	23,800	11.28	9
10	Activity Assistants	5,985	6,441	50,789	7.89	10
11	Social Service Workers	3,749	3,945	44,309	11.23	11
12	Dietician					12
13	Food Service Supervisor	2,034	2,283	41,419	18.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,902	14,105	112,604	7.98	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,135	33,690	15.78	17
18	Housekeepers	7,401	7,860	67,187	8.55	18
19	Laundry	7,391	8,069	67,360	8.35	19
20	Administrator	1,922	2,099	60,082	28.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,907	3,088	26,823	8.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,121	130,328	$ 1,667,407 *	$ 12.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	102	$ 4,845	1-3	35
36	Medical Director	180	6,000	9-3	36
37	Medical Records Consultant	49	2,464	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	660	10-3	39
40	Physical Therapy Consultant	17	994	10a-3	40
41	Occupational Therapy Consultant	5	228	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	2,521	11-3	44
45	Social Service Consultant	50	2,241	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	574	$ 19,953		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,894	$ 72,090	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,894	$ 72,090		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Safet Kaljalic	Administrator	N/A	$ 60,082
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,082

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 137,170
TOTAL (agree to Schedule V, line 17, col. 3)	$ 137,170
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Accounting	$ 1,205
Richard Peelo	Accounting	2,250
Personnel Planners	Payroll Tax Consultant	675
Winston & Strawn	Legal	490
Stone,Pogrund & Korey	Legal	5,097
MediFax EDI	Data Processing	90
Accu-Med Services, Inc.	Data Processing	2,700
HealthData Systems, Inc.	Data Processing	2,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 15,007

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,862
Unemployment Compensation Insurance	21,188
FICA Taxes	125,968
Employee Health Insurance	87,744
Employee Meals	10,748
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits	10,923
Retirement Plan Contributions	1,670
Holiday	3,990
Lancaster Allocation	22,022
TOTAL (agree to Schedule V, line 22, col.8)	$ 304,115

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
* N/A *		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 750
Advertising: Employee Recruitment	1,662
Health Care Worker Background Check	
(Indicate # of checks performed 4)	46
Advertising and Promotions	25,059
Licenses and Fees	1,528
Dues and Subscriptions	776
Lancaster Allocation	10,911
Less: Public Relations Expense	(9,979)
Non-allowable advertising	(24,215)
Yellow page advertising	(844)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,694

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	67
Lancaster Allocation	2,288
Seminar Expense	5,253
Lancaster Allocation	514
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,122

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Dolton Healthcare Centre # 0043141 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Painting & Decorating	10/2001	$ 11,652	3	$ 1,942	$ 3,884	$ 3,884	$ 3,884	$	$	$	$	$
2	Painting & Decorating	7/2003	11,344	3			1,891	1,891	3,781	1,891			
3													
4													
5													
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19													
20	TOTALS		$ 22,996		$ 1,942	$ 3,884	$ 5,775	$ 5,775	$ 3,781	$ 1,891	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,637** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **43,710**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,748** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **None**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.